FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042044

Facility Name: Washington Heights Nursing Home

Address: 1010 West 95th Street (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: (773) 298-1177 **Fax #** (773) 298-1666

HFS ID Number: 364100431001

Date of Initial License for Current Owners: 10/24/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	228	Skilled (SNF)	228	83,220	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	228	TOTALS	228	83,220	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,570	293	7,854	13,717	8
9	SNF/PED					9
10	ICF	56,313	2,960	1,042	60,315	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,883	3,253	8,896	74,032	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.96%

D. How many bed-hold days during this year were paid by the Department?
38 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/24/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/24/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 228 and days of care provided 7,751

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Washington Heights Nursing Home # 0042044 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	372,780	104,835	22,035	499,650		499,650	(3,599)	496,051			1
2	Food Purchase		322,768		322,768	(40,734)	282,034	8,752	290,786			2
3	Housekeeping	254,072	56,509		310,581		310,581	(4,761)	305,820			3
4	Laundry	106,816	31,300		138,116		138,116		138,116			4
5	Heat and Other Utilities			280,763	280,763		280,763	2,927	283,690			5
6	Maintenance	84,029	152	339,463	423,644		423,644	7,993	431,637			6
7	Other (specify):*							10,474	10,474			7
8	**TOTAL General Services**	817,697	515,564	642,261	1,975,522	(40,734)	1,934,788	21,786	1,956,574			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,275,278	92,378	133,041	3,500,697		3,500,697	(7,608)	3,493,089			10
10a	Therapy	151,448		1,843	153,291		153,291	699	153,990			10a
11	Activities	168,760	11,876	2,352	182,988		182,988		182,988			11
12	Social Services	156,203	1,630	1,517	159,350		159,350		159,350			12
13	CNA Training											13
14	Program Transportation			335	335		335		335			14
15	Other (specify):*							3,389	3,389			15
16	**TOTAL Health Care and Programs**	3,751,689	105,884	151,088	4,008,661		4,008,661	(3,520)	4,005,141			16
	C. General Administration											
17	Administrative	96,900			96,900		96,900	44,420	141,320			17
18	Directors Fees											18
19	Professional Services			379,807	379,807		379,807	(301,948)	77,859			19
20	Dues, Fees, Subscriptions & Promotions			96,041	96,041		96,041	(33,179)	62,862			20
21	Clerical & General Office Expenses	137,353	23,247	646,323	806,923		806,923	(340,260)	466,663			21
22	Employee Benefits & Payroll Taxes			845,726	845,726	40,734	886,460	(11,284)	875,176			22
23	Inservice Training & Education			45	45		45		45			23
24	Travel and Seminar			2,219	2,219		2,219	6,752	8,971			24
25	Other Admin. Staff Transportation			11,561	11,561		11,561	(9,516)	2,045			25
26	Insurance-Prop.Liab.Malpractice			266,892	266,892		266,892	2,825	269,717			26
27	Other (specify):*							39,261	39,261			27
28	**TOTAL General Administration**	234,253	23,247	2,248,614	2,506,114	40,734	2,546,848	(602,929)	1,943,919			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,803,639	644,695	3,041,963	8,490,297		8,490,297	(584,664)	7,905,633			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Washington Heights Nursing Home #0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			81,591	81,591		81,591	356,976	438,567			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,368	53,368		53,368	458,804	512,172			32
33	Real Estate Taxes			328,808	328,808		328,808	2,406	331,214			33
34	Rent-Facility & Grounds			1,266,222	1,266,222		1,266,222	(1,254,826)	11,396			34
35	Rent-Equipment & Vehicles			12,142	12,142		12,142	2,118	14,260			35
36	Other (specify):*			3,814	3,814		3,814	55,422	59,236			36
37	TOTAL Ownership			1,745,945	1,745,945		1,745,945	(379,100)	1,366,845			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		519,501	365,873	885,374		885,374	(51,167)	834,207			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,830	124,830		124,830		124,830			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		519,501	490,703	1,010,204		1,010,204	(51,167)	959,037			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,803,639	1,164,196	5,278,611	11,246,446		11,246,446	(1,014,931)	10,231,515			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	79,015	30		9
10	Interest and Other Investment Income	(291,770)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(139)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(33,949)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(336,894)	21		24
25	Fund Raising, Advertising and Promotional	(37,462)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(262,948)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (885,147)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(129,784)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (129,784)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,014,931)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Washington Heights Nursing Home

ID# 0042044

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (73)	10	1
2	Patient Clothing	(152)	10	2
3	Theft Loss	(285)	21	3
4	Collection Expense	(2,270)	21	4
5	Capitalized R&M	(5,720)	6	5
6	Non-allowable Billing Service	(7,583)	19	6
7	Out of Period Expense	(28)	21	7
8	FY-2006 Seminar	(75)	24	8
9	Prior Year Legal	(735)	19	9
10	Non-Allowable Expense	(204,000)	21	10
11	COPE Dues	(822)	20	11
12	Related Party Interest Expense	(40,828)	32	12
13	Building Company - Misc. Expense	(377)	21	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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100				100
101	**Total**	(262,948)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Heights Nursing Home # 0042044 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					465		(3,018)	(1,046)				(3,599)	1
2	Food Purchase	(139)							8,891				8,752	2
3	Housekeeping				(4,761)								(4,761)	3
4	Laundry													4
5	Heat and Other Utilities					2,927							2,927	5
6	Maintenance	(5,720)			(16)	7,153		6,452	124				7,993	6
7	Other (specify):*						6,914	1,689	1,871				10,474	7
8	**TOTAL General Services**	(5,859)			(4,777)	10,545	6,914	5,123	9,840				21,786	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(225)			(7,383)								(7,608)	10
10a	Therapy							699					699	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						3,293	96					3,389	15
16	**TOTAL Health Care and Programs**	(225)			(7,383)		3,293	795					(3,520)	16
	C. General Administration													
17	Administrative					4,796		38,719	905				44,420	17
18	Directors Fees													18
19	Professional Services	(8,318)				(293,650)			20				(301,948)	19
20	Fees, Subscriptions & Promotions	(39,284)			(211)	6,290			26				(33,179)	20
21	Clerical & General Office Expenses	(577,803)	377			23,379		211,708	2,079				(340,260)	21
22	Employee Benefits & Payroll Taxes				(105)		(11,179)						(11,284)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(75)				6,107			720				6,752	24
25	Other Admin. Staff Transportation					(9,516)							(9,516)	25
26	Insurance-Prop.Liab.Malpractice					2,182			643				2,825	26
27	Other (specify):*						3,331	35,930					39,261	27
28	**TOTAL General Administration**	(625,480)	377		(316)	(260,412)	(7,848)	286,357	4,393				(602,929)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(631,564)	377		(12,477)	(249,867)	2,359	292,275	14,233				(584,664)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Washington Heights Nursing Home **#** 0042044 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	79,015	242,970			30,486			345	4,160			356,976	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(332,598)	783,684			5,089			1,157	1,472			458,804	32
33	Real Estate Taxes					2,406							2,406	33
34	Rent-Facility & Grounds		(1,266,222)			11,396							(1,254,826)	34
35	Rent-Equipment & Vehicles					2,053			65				2,118	35
36	Other (specify):*		55,422										55,422	36
37	TOTAL Ownership	(253,583)	(184,146)			51,430			1,567	5,632			(379,100)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(12,905)				(25,762)	(12,500)			(51,167)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers				(12,905)				(25,762)	(12,500)			(51,167)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(885,147)	(183,769)		(25,382)	(198,437)	2,359	292,275	(9,962)	(6,868)			(1,014,931)	45

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Washington Hts Property LLC		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent	$ 1,266,222	Washington Heights Property LLC	100.00%	$	$ (1,266,222)	1
2	V		32	Interest Income	53,368	Washington Heights Property LLC	100.00%		(53,368)	2
3	V		21	Misc Expense		Washington Heights Property LLC	100.00%	377	377	3
4	V		30	Depreciation		Washington Heights Property LLC	100.00%	242,970	242,970	4
5	V		36	Amortization		Washington Heights Property LLC	100.00%	55,422	55,422	5
6	V		32	Interest		Washington Heights Property LLC	100.00%	837,052	837,052	6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 1,319,590			$ 1,135,821	$ * (183,769)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 82,504	$ 82,504	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	82,504	CCS EMPLOYEE BENEFIT GROUP	100.00%		(82,504)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 82,504			$ 82,504	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$	XCEL MEDICAL SUPPLY, LLC	100.00%	$	$	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	48,020	XCEL MEDICAL SUPPLY, LLC	100.00%	43,259	(4,761)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	161	XCEL MEDICAL SUPPLY, LLC	100.00%	145	(16)	19
20	V	10	NURSING	74,474	XCEL MEDICAL SUPPLY, LLC	100.00%	67,091	(7,383)	20
21	V	11	ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	20	DUES, FEES, SUBSCRIPTIONS & PROM	2,130	XCEL MEDICAL SUPPLY, LLC	100.00%	1,919	(211)	22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	1,060	XCEL MEDICAL SUPPLY, LLC	100.00%	955	(105)	24
25	V	39	ANCILLARY	130,169	XCEL MEDICAL SUPPLY, LLC	100.00%	117,264	(12,905)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 256,015			$ 230,633	$ * (25,382)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 465	$ 465	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	2,927	2,927	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	7,153	7,153	17
18	V				Care Centers, Inc.	100.00%			18
19	V	17	Administration		Care Centers, Inc.	100.00%	4,796	4,796	19
20	V	19	Professional Fees	320,505	Care Centers, Inc.	100.00%	26,855	(293,650)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	6,290	6,290	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	23,379	23,379	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	6,107	6,107	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	2,182	2,182	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	30,486	30,486	25
26	V	32	Interest		Care Centers, Inc.	100.00%	5,089	5,089	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,406	2,406	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	11,396	11,396	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,053	2,053	29
30	V	25	Bus Reimbursement	9,516	Care Centers, Inc.	100.00%		(9,516)	30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 330,021			$ 131,584	$ * (198,437)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 44,147	Care Centers, Inc.	100.00%	$ 44,147	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	6,914	6,914	16
17	V	10	Nursing Salary	20,161	Care Centers, Inc.	100.00%	20,161		17
18	V	10a	Rehab Salary	1,771	Care Centers, Inc.	100.00%	1,771		18
19	V								19
20	V								20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	3,293	3,293	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	19,027	Care Centers, Inc.	100.00%	19,027		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	3,331	3,331	24
25	V	22	Employee Benefits	11,179	Care Centers, Inc.	100.00%		(11,179)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,285			$ 98,644	$ * 2,359	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 8,322	Care Centers, Inc.	100.00%	$ 5,304	$ (3,018)	15
16	V								16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	6,452	6,452	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,689	1,689	18
19	V								19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	699	699	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	96	96	21
22	V								22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	38,719	38,719	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	211,708	211,708	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	35,930	35,930	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,322			$ 300,597	$ * 292,275	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 16,901	Care Centers, Inc. - Health Systems Division	100.00%	$ 3,531	$ (13,370)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	8,891	8,891	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	124	124	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	905	905	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	20	20	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	26	26	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	2,079	2,079	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	720	720	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	643	643	23
24	V	30	Depreciaton		Care Centers, Inc. - Health Systems Division	100.00%	345	345	24
25	V	32	Interest		Care Centers, Inc. - Health Systems Division	100.00%	1,157	1,157	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	65	65	26
27	V	39	Ancillary Enteral Supplies	54,360	Care Centers, Inc. - Health Systems Division	100.00%	28,598	(25,762)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	12,324	12,324	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	1,871	1,871	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 71,261			$ 61,299	$ * (9,962)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 4,160	$ 4,160	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	1,472	1,472	16
17	V	39	Vent Reimbursement	12,500	Vent Lease, LLC.	100.00%		(12,500)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,500			$ 5,632	$ * (6,868)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Aronin	Owner	Administrative	0.89%	see attached	1.94	3.46%	Alloc Salary	$ 6,196	17-7	1
2	Eric Rothner	Relative	Administrative	0.00%	see attached	1.57	3.40%	Alloc Salary	3,778	17-7	2
3	Gale Rothner	Relative	Administrative	0.00%	see attached	1.73	4.94%	Alloc Salary	3,857	17-7	3
4	Mark Steinberg	Relative	Administrative	0.00%	see attached	2.72	4.95%	Alloc Salary	3,638	17-7	4
5	Adam Vales	Relative	Clerical	0.00%	see attached	0.55	1.38%	Alloc Salary	673	22-7	5
6	Kim Rudolph	Relative	Clerical	0.00%	see attached	0.66	1.89%	Alloc Salary	1,169	22-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,311		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURAI	DIRECT ALLOCATION			$	$		$ 82,504	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 82,504	25

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 W. MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						43,259	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						145	5
6	10	NURSING	Direct Allocation						67,091	6
7	11	ACTIVITIES	Direct Allocation							7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						1,919	8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						955	10
11	39	ANCILLARY	Direct Allocation						117,264	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 230,633	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,497,287	32	$ 9,406	$	74,032	$ 465	1
2	05	Utilities	Patient Days	1,497,287	32	59,188		74,032	2,927	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661		74,032	7,153	3
4										4
5	17	Administration	Patient Days	1,497,287	32	97,000		74,032	4,796	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148		74,032	26,855	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217		74,032	6,290	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845		74,032	23,379	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511		74,032	6,107	9
10	26	Insurance	Patient Days	1,497,287	32	44,126		74,032	2,182	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575		74,032	30,486	11
12	32	Interest	Patient Days	1,497,287	32	102,930		74,032	5,089	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662		74,032	2,406	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488		74,032	11,396	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530		74,032	2,053	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,661,288	$		$ 131,584	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			301,710	301,710		44,147	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			46,639			6,914	2
3	10	Nursing Salary	Direct Cost			425,833	425,833		20,161	3
4	10a	Rehab Salary	Direct Cost			55,464	55,464		1,771	4
5										5
6										6
7	15	Emp. Ben. - Healthcare	Direct Cost			67,757			3,293	7
8	17	Administration Salary	Direct Cost			5,566	5,566			8
9	21	Office Salary	Direct Cost			419,879	419,879		19,027	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			71,906			3,331	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,394,755	$ 1,208,453		$ 98,644	25

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	74,032	5,304	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	74,032	6,452	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		74,032	1,689	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	74,032	699	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		74,032	96	7
8					32					8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	74,032	38,719	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	74,032	211,708	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		74,032	35,930	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,079,517	$ 5,316,753		$ 300,597	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	928,452		46,000		71,262	3,531	1
2	02	Food	Income			160,931			8,891	2
3	06	Maintenance	Billable Income	928,452		1,614		71,262	124	3
4	17	Administration	Billable Income	928,452		11,797		71,262	905	4
5	19	Professional Fees	Billable Income	928,452		262		71,262	20	5
6	20	Dues & Subscriptions	Billable Income	928,452		342		71,262	26	6
7	21	Office & Clerical	Billable Income	928,452		27,087		71,262	2,079	7
8	24	Travel & Seminar	Billable Income	928,452		9,381		71,262	720	8
9	26	Insurance	Billable Income	928,452		8,379		71,262	643	9
10	30	Depreciaton	Billable Income	928,452		4,499		71,262	345	10
11	32	Interest	Billable Income	928,452		15,077		71,262	1,157	11
12	35	Rent - Equipment & Auto	Billable Income	928,452		843		71,262	65	12
13	39	Ancillary Enteral Supplies	Income			327,517			28,598	13
14	01	Dietary - Salary	Billable Income	928,452		160,568	160,568	71,262	12,324	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452		24,382		71,262	1,871	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 798,679	$ 160,568		$ 61,299	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	593,410	29	$ 197,493	$	12,500	$ 4,160	1
2	32	Interest	Direct Billing	593,410	29	69,863		12,500	1,472	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 267,356	$		$ 5,632	25

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Corus Bank		X	Mortgage			$	$			$ 467,455	1
2	Business Partners, LLC		X	Mortgage				10,415,339			328,768	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Building Company		X	Working Capital							53,368	6
7	South Shore Property	X		Working Capital							40,828	7
8	See Supplemental Schedule										7,718	8
9	TOTAL Facility Related						$	$ 10,415,339			$ 898,137	9
	B. Non-Facility Related*											
10	Interest Income										(291,770)	10
11	Interest Income (Bldg Co)										(53,368)	11
12	Related Party Interest										(40,828)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (385,966)	14
15	TOTALS (line 9+line14)						$	$ 10,415,339			$ 512,171	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc from Vent Lease		X				$	$			$ 1,472	8
9	Alloc from Care Centers		X								6,246	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										7,718	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 330,286	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 323,919	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,367)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 337,589	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 331,222	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	337,917	8
	2001	346,759	9
	2002	350,493	10
	2003	314,561	11
	2004	321,513	12

2005 Accrual = 2004 Tax $321,513 x 1.05 = $337,589

Allocated from Care Center $2406

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Heights Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-423-001-0000	Long Term Care Property	$ 1,196.05	$ 1,196.05
2.	25-05-423-002-0000	Long Term Care Property	$ 1,320.00	$ 1,320.00
3.	25-05-423-003-0000	Long Term Care Property	$ 1,508.82	$ 1,508.82
4.	25-05-423-004-0000	Long Term Care Property	$ 1,462.32	$ 1,462.32
5.	25-05-423-005-0000	Long Term Care Property	$ 7,728.15	$ 7,728.15
6.	25-05-423-006-0000	Long Term Care Property	$ 39,621.35	$ 39,621.35
7.	25-05-423-007-0000	Long Term Care Property	$ 47,781.89	$ 47,781.89
8.	25-05-423-008-0000	Long Term Care Property	$ 123,439.22	$ 123,439.22
9.	25-05-423-009-0000	Long Term Care Property	$ 97,455.47	$ 97,455.47
10.	See Attached	Home Office Allocation	$ 113,458.70	$ 2,406.07
		TOTALS	$ 434,971.97	$ 323,919.34

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Heights Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042044

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,255 B. General Construction Type: Exterior Brick Frame Masonry/Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	85,244	1994	$ 251,898	1
2	Alloc from 2201 Main LLC			17,389	2
3	TOTALS	85,244		$ 269,287	3

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	21,522		20	1,077	1,077	10,178	9
10	Various			1997	179,381		20	8,971	8,971	75,823	10
11	Various			1998	71,893		20	3,596	3,596	27,057	11
12	Various			1999	54,109		20	2,705	2,705	17,432	12
13	Various			2000	102,147		20	5,618	5,618	31,805	13
14	Various			2001	61,238		20	3,063	3,063	14,850	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		10,226,094	242,970		254,542	11,572	2,300,916	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		68,247	2,796		2,796		8,429	68
69	Financial Statement Depreciation			81,591			(81,591)		69
70	TOTAL (lines 4 thru 69)		$ 10,784,631	$ 327,357		$ 282,368	$ (44,989)	$ 2,486,490	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,784,631	$ 327,357		$ 282,368	$ (44,989)	$ 2,486,490	1
2	Lift	2002	2,149		20	215	215	860	2
3	Stain Glass	2002	695		20	70	70	278	3
4	Basement Ramp Exit Door	2002	1,116		20	112	112	446	4
5	Patio Awning	2002	4,400		20	440	440	1,760	5
6	3Rd Floor Cafeteria Floor	2002	5,772		20	577	577	2,309	6
7	Repair On Sprinkler System	2002	1,233		20	247	247	986	7
8	Replace Pump	2002	1,562		20	312	312	1,250	8
9	Concrete Paving	2002	561		20	56	56	220	9
10	Roofing R&M	2002	950		20	95	95	372	10
11	A/C Repair	2002	506		20	101	101	396	11
12	A/C Repair	2002	816		20	163	163	639	12
13	Valve Repair	2002	844		20	169	169	661	13
14	A/C Repair	2002	585		20	117	117	458	14
15	A/C Repair	2002	870		20	174	174	682	15
16	A/C Repair	2002	684		20	137	137	536	16
17	R&M Fan Coil Units	2002	1,562		20	312	312	1,224	17
18	R&M Fan Coil Units	2002	863		20	173	173	676	18
19	A/C Repair	2002	506		20	101	101	396	19
20	A/C Repair	2002	863		20	173	173	647	20
21	Phone Jacks	2002	925		20	93	93	347	21
22	Phone Jacks	2002	925		20	93	93	339	22
23	A/C Repair	2002	546		20	109	109	391	23
24	Drapes	2002	932		20	93	93	334	24
25	R&M Fan Coil Units	2002	863		20	173	173	618	25
26	Carpeting	2002	29,566		20	2,957	2,957	10,348	26
27	R&M Fan Coil Units	2002	868		20	174	174	608	27
28	A/C Repair	2002	530		20	106	106	371	28
29	Plumbing R&M	2002	860		20	172	172	588	29
30	Flooring	2002	12,986		20	1,299	1,299	4,220	30
31	Sidewalk R&M	2002	1,820		20	182	182	592	31
32	Carpeting, Material, Labor & Tax	2002	4,381		20	438	438	1,424	32
33	Pipe R&M	2002	2,200		20	220	220	697	33
34	TOTAL (lines 1 thru 33)		$ 10,868,570	$ 327,357		$ 292,221	$ (35,136)	$ 2,522,163	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,868,570	$ 327,357		$ 292,221	$ (35,136)	$ 2,522,163	1
2	A/C Repair	2002	1,147		20	115	115	363	2
3	Draperies	2002	774		20	77	77	245	3
4	Crackfilling	2002	4,174		20	417	417	1,322	4
5	Ductwork	2002	1,740		20	174	174	551	5
6	Parkway Lighting	2002	744		20	74	74	236	6
7	Valve Repair	2002	781		20	156	156	495	7
8	Ceiling Tile	2003	585		20	59	59	176	8
9	Elevator Repair	2003	2,529		20	253	253	632	9
10	Exit Doors	2003	1,180		20	59	59	148	10
11	Elevator Doors	2004	3,187		20	159	159	319	11
12	Repair Elevator Door	2004	3,187		20	159	159	292	12
13	New Telephone System	2004	2,929		20	586	586	1,074	13
14	Midwest Mechanical	2004	575		20	58	58	105	14
15	New Telephone System	2004	2,670		20	534	534	979	15
16	Roof Repair	2004	1,200		20	120	120	180	16
17	Radio Controlled Doors	2004	4,763		20	476	476	675	17
18	Widen Driveway	2004	1,875		20	188	188	250	18
19	Widen Driveway	2004	2,000		20	200	200	267	19
20	Elevator Recall System	2004	2,200		20	110	110	147	20
21	Widen Driveway	2004	1,875		20	188	188	250	21
22	Back Lot Pavement	2004	2,685		20	269	269	358	22
23	Locks On Doors	2004	7,574		20	1,515	1,515	2,020	23
24	Piping & Wiring	2004	1,656		20	166	166	207	24
25	Lab To Remove Debris	2004	2,623		20	262	262	306	25
26	Repair Epdm Roof	2004	700		20	70	70	82	26
27	Fire Alarm System	2004	1,200		20	240	240	280	27
28	Elevator Recall System	2004	1,200		20	60	60	70	28
29	Lighting Maintenance	2004	578		20	58	58	63	29
30	Repair Epdm Roof	2004	650		20	65	65	70	30
31	Plumbing Maintenance	2004	1,300		20	130	130	141	31
32	Smoke Damper	2004	1,448		20	207	207	224	32
33	Zone Valve Thermostat	2004	1,020		20	204	204	221	33
34	TOTAL (lines 1 thru 33)		$ 10,931,319	$ 327,357		$ 299,629	$ (27,728)	$ 2,534,911	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,931,319	$ 327,357		$ 299,629	$ (27,728)	$ 2,534,911	1
2	Exhaust Fan	2004	1,223		20	245	245	265	2
3	Window Treatment Rods	2004	1,613		20	161	161	175	3
4	Hot Water Heater - Repair	2004	1,579		20	132	132	143	4
5	Hvac	2004	2,811		20	281	281	562	5
6	Repairs To Shower Rooms	2004	825		20	83	83	110	6
7	Hvac	2004	1,548		20	155	155	271	7
8	Pneumatic Thermostat And Installation	2004	1,117		20	112	112	168	8
9	Sprinkler Repairs	2004	556		20	51	51	51	9
10	Doors	2004	2,077		20	147	147	147	10
11	Generator Repair	2005	5,667		20	850	850	850	11
12	5 Oak Doors	2005	3,440		20	459	459	459	12
13	Plumbing For Catch Basin	2005	5,437		20	317	317	317	13
14	Hvac Repair	2005	1,519		20	32	32	32	14
15	Plumbing	2005	2,124		20	27	27	27	15
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,962,855	$ 327,357		$ 302,681	$ (24,676)	$ 2,538,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	228		1996	1996	$ 10,226,094	$ 242,970		$ 254,542	$ 11,572	$ 2,300,916	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,226,094	$ 242,970		$ 254,542	$ 11,572	$ 2,300,916	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC allocation		2002	2002	$ 23,963	$ 614		$ 614	$	$ 2,023	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from 2201 Main LLC			2002	19,796	990	20	990		3,464	9
10	Allocation from 2201 Main LLC			2003	23,329	1,166	20	1,166		2,916	10
11	Allocation from 2201 Main LLC			2005	1,159	26	20	26		26	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
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27											27
28											28
29											29
30											30
31											31
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34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 68,247	$ 2,796		$ 2,796	$	$ 8,429	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,073,820	$ 29,265	$ 132,130	$ 102,865	10	$ 900,825	71
72	Current Year Purchases	26,445	485	1,311	826	10	1,311	72
73	Fully Depreciated Assets	10,725				10	10,725	73
74								74
75	TOTALS	$ 1,110,990	$ 29,750	$ 133,441	$ 103,691		$ 912,861	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Centers Allocation		$ 33,388	$ 2,445	$ 2,445	$	5	$ 25,283	76
77										77
78										78
79										79
80	TOTALS			$ 33,388	$ 2,445	$ 2,445	$		$ 25,283	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,376,520	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 359,552	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 438,567	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 79,015	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,476,632	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocation from Care Centers				11,396			6
7	TOTAL				$ 11,396 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 14,260 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 197,990	$		$ 197,990	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			24,141			24,141	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			131,396			131,396	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			12,346	275,344		287,690	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						244,157		244,157	13
14	TOTAL			$		$ 365,873	$ 519,501		$ 885,374	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,000	$ 307,754	1
2	Cash-Patient Deposits	55,290	55,290	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,556,134	1,893,734	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	313,890	313,890	6
7	Other Prepaid Expenses	20,215	20,215	7
8	Accounts Receivable (owners or related parties)		15,170	8
9	Other(specify): See Attached Schedule	4,172,188	4,267,188	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,118,717	$ 6,873,241	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		251,898	13
14	Buildings, at Historical Cost		8,473,923	14
15	Leasehold Improvements, at Historical Cost	540,629	975,693	15
16	Equipment, at Historical Cost	411,632	2,397,059	16
17	Accumulated Depreciation (book methods)	(597,786)	(4,860,983)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		156,825	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 354,475	$ 7,394,415	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,473,192	$ 14,267,656	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,533,894	$ 1,871,493	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,241	55,241	28
29	Short-Term Notes Payable	1,045,670		29
30	Accrued Salaries Payable	176,177	176,177	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,762	4,762	31
32	Accrued Real Estate Taxes(Sch.IX-B)	337,589	337,589	32
33	Accrued Interest Payable		57,849	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule		155,015	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,153,333	$ 2,658,126	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		10,415,339	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 10,415,339	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,153,333	$ 13,073,465	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,319,859	$ 1,194,191	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,473,192	$ 14,267,656	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,990,527	1
2	Restatements (describe):		2
3	**Prior Period Income**	20,298	3
4	**Restate Accum Depr to GAAP**	(2,461)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,008,364	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(509,505)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(179,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (688,505)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,319,859	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,273,853	1
2	Discounts and Allowances for all Levels	(1,925,341)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,348,512	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,660,572	6
7	Oxygen	7,677	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,668,249	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	275,205	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	68,549	19
20	Radiology and X-Ray	13,230	20
21	Other Medical Services	71,353	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 428,337	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	291,770	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 291,770	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	73	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 73	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,736,941	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,975,522	31
32	Health Care	4,008,661	32
33	General Administration	2,506,114	33
	B. Capital Expense		
34	Ownership	1,745,945	34
	C. Ancillary Expense		
35	Special Cost Centers	885,374	35
36	Provider Participation Fee	124,830	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,246,446	40
41	**Income before Income Taxes (line 30 minus line 40)****	(509,505)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (509,505)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,063	2,307	$ 83,280	$ 36.10	1
2	Assistant Director of Nursing	4,025	5,919	180,789	30.54	2
3	Registered Nurses	15,079	17,785	445,328	25.04	3
4	Licensed Practical Nurses	52,916	58,007	1,289,375	22.23	4
5	CNAs & Orderlies	122,588	133,481	1,257,593	9.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,997	10,035	151,448	15.09	8
9	Activity Director	1,855	2,293	31,694	13.82	9
10	Activity Assistants	15,717	17,018	137,066	8.05	10
11	Social Service Workers	10,727	12,357	156,203	12.64	11
12	Dietician					12
13	Food Service Supervisor	3,195	3,847	56,982	14.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,828	7,965	83,404	10.47	15
16	Dishwashers	26,695	29,159	232,394	7.97	16
17	Maintenance Workers	6,392	6,539	84,029	12.85	17
18	Housekeepers	28,280	30,681	254,072	8.28	18
19	Laundry	12,153	13,369	106,816	7.99	19
20	Administrator	1,994	2,119	65,853	31.08	20
21	Assistant Administrator	1,609	1,409	31,047	22.03	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,309	11,117	137,353	12.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,448	1,467	18,913	12.89	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	332,870	366,874	$ 4,803,639 *	$ 13.09	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	310	$ 13,713	01-03	35
36	Medical Director	96	12,000	09-03	36
37	Medical Records Consultant	monthly	1,023	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,420	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,352	11-03	44
45	Social Service Consultant	27	1,517	12-03	45
46	Other(specify)				46
47	Therapy Consultant		72	10A-03	47
48	CCI - see attached		30,254	various	48
49	TOTAL (lines 35 - 48)	481	$ 64,351		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,056	$ 55,821	10-03	50
51	Licensed Practical Nurses	1,545	52,616	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,601	$ 108,437		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Curtis	Administrator	0	$ 6,666
Melody Parks	Administrator	0	59,187
Melody Parks	Asst Admin	0	5,257
Daria Warnock	Asst Admin	0	25,790
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,900

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Care Centers, Inc.	Home Office Expense	$ 191,520
Care Centers, Inc.	Legal	20,805
Care Centers, Inc.	Accounting	15,000
Care Centers, Inc.	Data Processing	8,208
Care Centers, Inc.	Bookkeeping	46,512
Care Centers, Inc.	Professional Fees	11,100
Care Centers, Inc.	Ancillary Admin. Service	27,360
Frost Ruttenberg & Rothblatt	Accounting	18,000
ADP, Inc.	Payroll Processing	13,581
eHealth Data Solutions	MDS Software	1,770
Personnel Planners	Unemployment Consultant	4,564
See Supplemetal Schedule		21,385
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 379,805

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 124,957
Unemployment Compensation Insurance	146,143
FICA Taxes	363,942
Employee Health Insurance	133,504
Employee Meals	40,734
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Employer Taxes	6,529
Employee Physicals	1,104
Pension Expense	38,786
Other Employee Welfare	16,563
Holiday Expense	2,914
TOTAL (agree to Schedule V, line 22, col.8)	$ 875,176

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,815
Advertising: Employee Recruitment	19,186
Health Care Worker Background Check	7,377
(Indicate # of checks performed 386)	
Dues & Subscriptions	26,077
Licenses & Fees	2,091
Advertising & Promotion	37,462
Allocation from Care Centers	6,316
Less: Public Relations Expense	( )
Non-allowable advertising	(37,462)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 62,862

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,144
Allocation from Care Centers	6,827
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,971

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Washington Heights Nursing Home # 0042044 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $23,893**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,076** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **124,830**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **40,734** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.